

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-030581

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

7636

STATE FILE NUMBER

FILED AUG 1 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)

St. Louis

Length of stay in 1b

152 da

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Mo

b. COUNTY

Inside Limits

Yes ☐ No ☐

c. CITY

OR

TOWN

St. Louis

d. STREET

ADDRESS

(If outside, give location)

1334 Franklin

Reside on Farm

Yes ☐ No ☐3. NAME OF DECEASED
(Type or print)

First

James

Middle

Therman

Last

4. DATE

OF

DEATH

Month

7-

Day

Year

63

5. SEX

M

6. COLOR OR RACE

N

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☐

8. DATE OF BIRTH

Unk. -03

9. AGE (last birthday)

about 60

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HR

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Unknown

10b. KIND OF BUSINESS OR INDUSTRY

Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

15. WAS DECEASED EVER IN U.S. ARMED FORCES
(Yes, no, or unknown) (If yes, give war or dates)

unknown

TY NO.

17. INFORMANT

Address

Chronic Hospital Records

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Carcinoma of Colon - metastatic

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

DUE TO (c)

153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes☐ No☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

Month, Day, Year

a.m.

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 2-1-63 to 7-3-63

Death occurred at 5:15 PM

and last saw her alive on 7-3-63

on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Ann Higgins, M.D.

22b. ADDRESS

634 N. Grand

22c. DATE SIGNED

7-5-63

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

7-31-63

23c. NAME OF CEMETERY OR CREMATORY

Anatomical Board

23d. LOCATION (City, town, or county)

St. Louis, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

Ogden, 4106 Manchester

25. DATE RECD. BY LOCAL REG.

JUL 25 1963

26. REGISTRAR'S SIGNATURE

Lois Smith, M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO.

INSTEAD OF

DATE AMENDED

BY AFFIDAVIT OF

DOCUMENT

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a **STUDENT**, he also shall sign in his **OWN handwriting**.

If this body is not embalmed, fact should be so stated above.